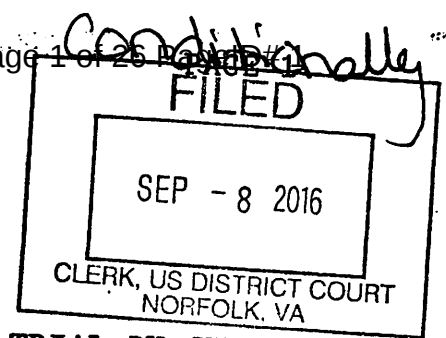


UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF VIRGINIA



RETCNICK FAUSTEN
Plaintiff

PLAINTIFF DEMANDS TRIAL BY JURY

v.

CENTRAL FINANCIAL CONTROL.
Defendant.

2:16cv533

COMPLANT

- 1.) At all time hereinafter mentioned plaintiff was still is a resident of P.O. Box 124 Haynesville Va 22472..
- 2.) Defendant CENTRAL FINANCIAL CONTROL is a corporated incorated under the laws of UNITED STATE and having a main office at P.O Box 660873 Dallas TX 75266 is licensed to do business in UNITED STATES.
- 3.) The jurisdiction of this court is invoked pursuant to Fair Credit Reporting Act and the Fair Debt Collection Act Unfair and deceptive practices, Emotional distress.
- 3.) WHEREFORE PLAINTIFF DEMENDS: Compensatory- compensates (out pocket expense) copy, filling fee, office supply \$3,000.00. Punitive damages of \$ 300,000.00 General damages for emotional distress of \$100,000.00 Delate account number 964896193 on my credit report

clusion

Would like court find CENTRAL FINANCIAL CONTROL accountable for there deceptive business practices. Have suffer emotional distress furnishing notify defendant reporting agencies inaccurate incomplet information on my credit report. Defendant choose ignore viplate federal law and state law. Have exhibit of evidence of proof on the defendant would like court take action on this civil matter.

STATEMENT OF FACT

On November 04, 2014 I receive my credit report from Experian credit report agency showed original creditor ST MARYS MEDICAL CENTER for collection amount \$550 account number 964896193 and collection amount \$750 account number 971676309. So check with other credit agency Trans Union, Experian seen same information creditor ST MARYS MEDICAL CENTER sent letter Equifax, TransUnion, Experian start an investigation collection \$550 original creditor ST MARYS MEDICAL CENTER dated 3-26-2015 Credit agency advise that showed dispute all matter to CENTRAL FINANCIAL CONTROL address PO BOX 66044 ANAHEIM CA 92816 sent letter dated 4-17-2015 advising about collection original creditor ST MARYS MEDICAL CENTER collection \$550 reported on my credit report am disputing account number 964896193 service that never receive from ST MARYS MEDICAL CENTER. May 15, 2015 receive letter from CENTRAL FINANCIAL CONTROL copy of contract out line financial responsibility for charges resulting from medical services. Dont recall ever receiving service from ST MARYS MEDICAL CENTER August 8, 2009 but did receive service August 28, 2009 all so explaine that signature on contract August 8, 2009 dont match contract signature August 28, 2009. CENTRAL FINANCIAL CONTROL sent affidavit wich filed sent back Annette Leyva (Inquiry Resolution Specialist). Base on CENTRAL FINANCIAL CONTROL indicated deletions are not warranted. All so CENTRAL FINANCIAL CONTROL indicated that provied ST MARYS MEDICAL CENTER my I.D wich comfirm service. Ask CENTRAL FINANCIAL CONTROL copy of my I.D that was provied at the time of service August 8, 2009 told direct question to ST MARY MEDICAL CENTER about medical service record. 7-9-2015 sent letter ST MARYS MEDICAL CENTER asking about copy of I.D prove on August 8 2009 receive medical service did not receive copy of record from ST MARYS MEDICAL CENTER wich provie did not receive service from ST MARYS MEDICAL CENTER. Purpose for Fair credit reporting act fairness in repoting ensure accuracy CENTRAL FINANCIAL CONTROL did not demonstrate truthfull reporting statement there clent ST MARYS MEDICAL CENTER could not prove that receive service base on there record and contract that have two diffrent signature. Statment on my credit report cause damges that could lead unjust denial of credit or insurance. Suffer emotional distress process of time, energy cleaning inaccurate information on my credit report. CENTRAL FINANCIAL CONTROL represent ST MARYS MEDICAL CENTER resume full responsibility over this matter. CENTRAL FINANCIAL CONTROL use ruthless tactic to collect debt. Try my best effort to resolve this matter now it court to respond CENTRAL FINANCIAL CONTROL for there business practice violation of the law.

STATEMENT OF FACT

The defedant did not properly validate debt under the federal fair debt collection practices under exhibit L letter from the defedant September 16, 2015 asking me provided copy identification and social security card disputes validation. On exhibit N defedant sent letter which i recive dated november 3, 2015 any copy of records please contact st. mary medical center the defedant did not satisfy the validation-notice requirement debt- collection agency to a debtor must effectively convey the notice. The defedant apply unfair practices unconscionable means to collect debt after notice have been made that conditions service exhibit O exhibit P signature dont match sending out affidavit showing accounts warranted deletion. The defedant did not delete or correct debt provide right information to credit agencies which made credit score go down violate fair credit reporting act.

GROUNDS

Defendant violate Fair Credit Reporting Act
Defendant violate Debt collection Practices Act
Defendant violate Business practices
Defendant violate Emotional distress
Defendant committed fraud

EXHIBIT A

3-26-15

Dear Equifax

Since you did not advise me within 30 days your investigation of my dispute please confirm that you have deleted the disputed Medical/Health Care - St. Marys Medical Center FL Account #1971676309, Medical/Health St. Marys Medical Center FL Account #1964896193, Medical/Health care - Imaging Account #18840154. Please do this promptly and send me a corrected copy of my credit report. Also please ensure that this deleted trade line is not reinserted into my credit reports at some future date. Thank you very much for your prompt assistance in this matter. I Hope you have great day.

Sincerely yours

Happy consumer

Reticnick Faustsen

R. Faustsen

County/City of Richmond, Commonwealth of Virginia
The foregoing instrument was subscribed and sworn before me this

26 day of March, 2015.

Reticnick Faustsen
(Name of person seeking acknowledgement)

Patricia W. Hand
Notary Public

My Commission expires: 2-28-19
Notary Reg. No. 164858

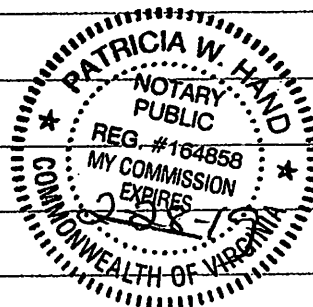


EXHIBIT B

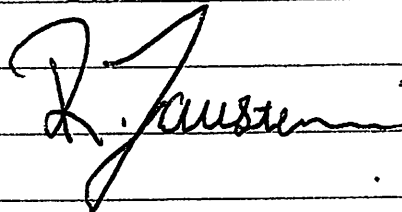
3-26-15

Dear ~~Exposition~~ TransUnion

Since you did not advise me within 30 days about your investigation of my dispute please confirm that you have deleted the disputed account Medical - ST MARYS MEDICAL CENTER FL (Medical/Health care) #96489, STMARYS MEDICAL CENTER FL (Medical/Health care) #97167. Please do this promptly and send me a corrected copy of my credit report. Also please ensure that this deleted trade line is not reinserted into my credit reports at some future date. Thank you very much for your prompt assistance in this matter. I hope you have great day.

Sincerely Yours,
Happy Consumer

Retenick Fausten



County/City of Richmond, Commonwealth of Virginia
The foregoing instrument was subscribed and sworn before me this

26th day of March, 2015.

Retenick Fausten
(Name of person seeking acknowledgement)

Patricia W. Hand
Notary Public

My Commission expires: 2-28-19
Notary Reg. No. 164858

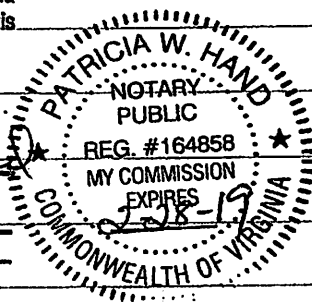


EXHIBIT C

3-26-15

Dear Experian

Since you did not advise me within 30 days about your investigation of my dispute please confirm that you have deleted the disputed account ST. MARYS MEDICAL CENTER FL #964896193, ST. MARYS MEDICAL CENTER FL #971676309. Please do this promptly and send me a corrected copy of my credit report. Also please ensure that this deleted trade line is not reinserted into my credit report at some future date. Thank you very much for your prompt assistance in this matter. I hope you have great day.

Sincerely yours.
Happy consumer

Retenick Fausten
R. Fausten

County of Richmond, Commonwealth of Virginia

The foregoing instrument was subscribed and sworn before me this

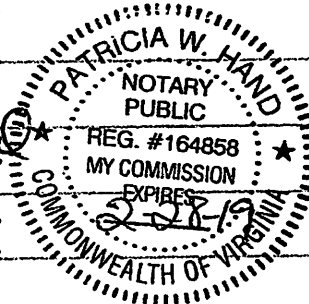
26th day of March, 2015

Retenick Fausten
(Name of person seeking acknowledgement)

Patricia W. Hand
Notary Public

My Commission expires: 2-28-19

Notary Reg. No. 164858



~~Case 2:16-cv-00533-AWA-LRL Document 1 Filed 09/08/16 Page 8 of 26 PageID# 8~~
~~EXHIBIT D~~



Prepared for: **RETCNICK FAUSTEN**
 Date: **November 04, 2014**
 Report number: **3202-0146-28**

Your accounts that may be considered negative (continued)

CENTRAL FINANCIAL CONTROL
 PO BOX 66044
 ANAHEIM CA 92816
 Phone number
 (900) 345 4261
 Partial account number
 971676309
 Address identification number
 0073947106
 Original creditor **ST. MARY S**
MEDICAL CENTER FL

Date opened
 Dec 2009
 First reported
 Feb 2010
 Date of status
 Feb 2010

Type
 Collection
 Terms
 1 Months
 Monthly
 payment
 Not reported

Credit limit or
 original amount
 \$750
 Recent balance
 \$750 as of Jan
 2013

Responsibility
 Individual
 Status
 Collection account
 This account is scheduled to continue on record until Jun
 2016.

Payment history

2013 2012											
JAN	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB
C	C	C	C	C	C	C	C	C	C	C	C

2011

JAN	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB
C	C	C	C	C	C	C	C	C	C	C	C

2010

JAN	DEC	NOV	OCT	SEP	AUG	JUL	JUN	MAY	APR	MAR	FEB
C	C	C	C	C	C	C	C	C	C	C	C

0553240353

Payment history legend

OK	Current/Terms of agreement met	V/S	Voluntarily surrendered
30	Account 30 days past due	R	Repossession
60	Account 60 days past due	PBC	Paid by creditor
90	Account 90 days past due	IC	Insurance claim
120	Account 120 days past due	G	Claim filed with government
150	Account 150 days past due	D	Defaulted on contract
180	Account 180 days past due	C	Collection
CRD	Creditor received deed	CO	Charge off
FS	Foreclosure proceedings started	CLS	Closed
F	Foreclosed	ND	No data for this time period

0553240353

TransUnion.

You have been on our files since 06/01/2003

Date of Birth: 02/14/1983

Addresses Reported:

Date Reported
01/23/2015

(561) 688-2646 (561) 396-9623 (561) 574-3600 (561) 502-7864 (561) 503-7864 (561) 242-8989

Some creditors report the timeliness of your payments each month in relation to your agreement with them. The ratings in the key below describe the payments that may be reported by your creditors. Any rating that is shaded indicates that it is considered adverse. Please note: Some but not all of these ratings may be present in your credit report.

N/R	X	OK	30	60	90	120	COL	VS	RPO	C/O	FC
Not Reported	Unknown	Current	30 days late	60 days late	90 days late	120+ days late	Collection	Voluntary Surrender	Repossession	Charge Off	Foreclosure

Estimated month and year that this item will be removed: 07/2016

P 4DKOC-003 01207-1009651 03/08

EQUIFAX

EXHIBIT F

CREDIT FILE : February 13, 2015**Personal Identification Information** (This section includes your name, current and previous addresses, and any other identifying information reported by your creditors.)

Name On File: Retenick Faustlin
 Social Security # XXX-XX-9286 Date of Birth: February 14, 1983
 Current Address: 5689 Mary Ln, West Palm Beach, FL 33407 (561) 688-2646 Reported: 02/2015
 Formerly Known As: Retnick Faustlin

Confirmation # 504404872**Please address all future correspondence to:**

www.investigate.equifax.com
 Equifax Information Services LLC
 Www. Equifax. Com/icra
 Atlanta GA 30348

(800) 377-6568

M - F 9:00am to 5:00pm in your time zone.

Collection Agency Information (This section includes accounts that credit grantors have placed for collection with a collection agency.)

Syndicated Office Systems: Collection Reported 12/2014; Assigned 12/2009; Creditor Class - Medical/Health Care; Client - St Mary S Medical Center FL; Amount - \$750 ; Status as of 12/2014 - Unpaid; Date of 1st Delinquency 09/2009; Balance as of 12/2014 - \$750 ; Individual Account; Account # - 971676309; ADDITIONAL INFORMATION - Consumer Disputes After Resolution; Address: PO Box 660873 Dallas TX 75266-0873 : (800) 345-4261

Syndicated Office Systems: Collection Reported 12/2014; Assigned 11/2009; Creditor Class - Medical/Health Care; Client - St Mary S Medical Center FL; Amount - \$550 ; Status as of 12/2014 - Unpaid; Date of 1st Delinquency 08/2009; Balance as of 12/2014 - \$550 ; Individual Account; Account # - 964896193; ADDITIONAL INFORMATION - Consumer Disputes After Resolution; Address: PO Box 660873 Dallas TX 75266-0873 : (800) 345-4261

Doctors Business Bureau; Collection Reported 03/2010; Assigned 12/2009; Creditor Class - Medical/Health Care; Client - IMAGING Associates; Amount - \$98 ; Status as of 03/2010 - Unpaid; Date of 1st Delinquency 08/2009; Balance as of 03/2010 - \$98 ; Individual Account; Account # - 8840154; Address: 202 N Federal Hwy Lake Worth FL 33460-3438 : (800) 841-3314

Inquiries that do not display to companies (do not impact your credit score)

(This section includes inquiries which display only to you and are not considered when evaluating your credit worthiness. - examples of this inquiry type include a pre-approved offer of credit, insurance, or periodic account review by an existing creditor.)

Company Information - Prefix Descriptions:

PRM - Inquiries with this prefix indicate that only your name and address were given to a credit grantor so they can provide you a firm offer of credit or insurance. (PRM inquiries remain for 12 months)
 PR - Inquires with this prefix indicate that a creditor reviewed your account as part of a portfolio they are purchasing. (PR Inquires remain for 12 months)
 AM or AR - Inquiries with these prefixes indicate a periodic review of your credit history by one of your creditors. (AM and AR inquiries remain for 12 months)
 Equifax or EFX - Inquiries with these prefixes indicate Equifax's activity in response to your contact with us for a copy of your credit file or a research request.
 ND - Inquiries with this prefix are general inquiries that do not display to credit grantors. (ND inquiries remain for 24 months)
 ND MR - Inquiries with this prefix indicate the reissue of a mortgage credit report containing information from your Equifax credit file to another company in connection with a mortgage loan. (ND MR inquiries remain for 24 months)
 EMPL - Inquiries with this prefix indicate an employment inquiry. (EMPL inquiries remain for 24 months)

Company Information

Company Information	Inquiry Date(s)
Equifax	02/13/2015
PO Box 740241 Atlanta, GA 30374-0241 Phone: (800) 685-1111	04/16/2013
ND-Suntrust Bank, North Central	
PO Box 85526 Cr Bur Disp CS-RVW7955 Richmond, VA 23285-5526 Phone: (877) 596-5407	

Equifax

PO Box 740241 Atlanta, GA 30374-0241 Phone: (800) 685-1111

ND-Suntrust Bank, North Central

PO Box 85526 Cr Bur Disp CS-RVW7955 Richmond, VA 23285-5526 Phone: (877) 596-5407

02/13/2015

04/16/2013

**** End of Credit File ****

Page 3 of 8

5044048721JU-001879184-526 - 2387 - ASD



Central Financial Control

P.O. Box 660873
Dallas, TX 75266-0873

(888)233-7880 Phone
(714)937-3427 Fax

May 15, 2015

Retnick Fausten
P.O. Box 129
Haynesville, VA 22472

Patient Name: Retnick Faustin
CFC Numbers: 964896193 and 971676309
Facility: St. Mary's Medical Center
Dates of Services: August 8, 2009 and August 28, 2009

Dear Mr. Fausten:

Our office is in receipt of your dispute letter requesting debt validation.

The aforementioned accounts result from services rendered by our client, St. Mary's Medical Center. The Conditions of Services (COS) is the contract that outlines your financial responsibility for any charges incurred resulting from medical services rendered by our client. Please be advised, the COS also grants the facility permission to transfer the accounts to a collection agency. A copy of the COS was available to you upon each admission to the facility. A copy of each COS is enclosed for your review.

CFC Number: 964896193

Date of Service: August 8, 2009

No insurance information was provided at the time of service. As a courtesy to their uninsured patients, our client reduced your account balance from \$1,630.00 to \$550.00 to reflect the Discount for the Uninsured Program rate. The outstanding balance on the account is \$550.00, which remains due and owing.

CFC Number: 971676309

Date of Service: August 28, 2009

No insurance information was provided at the time of service. As a courtesy to their uninsured patients, our client reduced your account balance from \$2,128.00 to \$750.00 to reflect the Discount for the Uninsured Program rate. The outstanding balance on the account is \$750.00, which remains due and owing.

Under this office's obligations to and with the credit reporting agencies (CRAs), we are contractually obligated to report delinquent accounts. Since you were duly notified of the debts in question prior to reporting, deletions are not warranted. Per our contract with the CRAs, we do not accept payment for deletion of items on your credit report. Once payment in full is received, our office will advise the CRAs to update your credit profile accordingly.

The accounts in question have been validated. Please contact (800) 300-7192 to discuss payment options.

Sincerely,

Annette Leyva
Inquiry Resolution Specialist

Enclosures: Conditions of Services

This is an attempt to collect a debt by a debt collector; any information obtained will be used for that purpose.

Any call may be monitored or recorded for quality assurance.

EXHIBIT J



Central Financial Control

P.O. Box 660873
Dallas, TX 75266-0873

(888)233-7880 Phone
(714)937-3427 Fax

June 19, 2015

Retcnick Fausten
P.O. Box 129
Haynesville, VA 22472

Patient Name:	Retcnick Faustin
CFC Numbers:	964896193 and 971676309
Facility:	St. Mary's Medical Center
Dates of Services:	August 8, 2009 and August 28, 2009

Dear Mr. Fausten:

In response to your correspondence dated August 20, 2015, our office has again reviewed your accounts.

According to your letter the signatures on the Conditions of Services (COS) are different and you believe the contract dated August 8, 2009 is not yours. Please be advised, during the admission process for this date of service, you provided our client with your driver's license to verify your identity, further evidencing your signature.

As per our original response, copies of each signed COS were provided, for your convenience. If you would like copies of your medical records or additional details to further substantiate the services rendered to you, you are welcome to request copies of your medical records from St. Mary's Medical Center directly.

Sincerely,

Annette Leyva
Inquiry Resolution Specialist

RECEIVED BY

EXHIBIT U

JUL 20 2015

HEALTHPORT

7-9-15

*Missing
Identified
L-52*

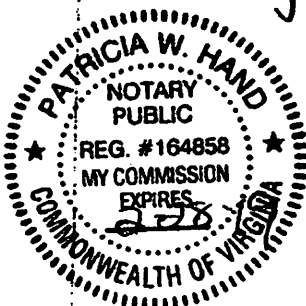
Retenick Fausten 1200865
Haynesville Correctional Center
P.O. Box 129 Haynesville VA 22472

Patient Name: Retenick Faustin

Facility: St. Mary's Medical Center

Dates of Services: August 8, 2009 and August 28, 2009

Am told central financial Control debit collector
wich have my information attempt to collect debt on
your behalf St. Mary's Medical Center. Am challenging
Contract date of service August 8, 2009 am told
central financial Control that provided driver's
license you have copy of all document that could prove
identity. Am questioning my signature that does not
match signature contract date of service August 28, 2009
with that said am requesting all medical records
from you to support that receive service on August 8, 2009
August 28, 2009 Send Medical records Haynesville
Correctional Center P.O. Box 129 Haynesville VA 22472
this letter will be notarize making this legal document
asking for document giving you 30 days answer befor
take legal action.



R. Faustin

County/City of Richmond, Commonwealth of Virginia
The foregoing instrument was subscribed and sworn before me this

day of July, 2015
Retenick Fausten
(Name of person seeking acknowledgment)

Patricia W. Hand
Notary Public
My Commission expires: 2-28-17
Notary Reg. No. 164858

EXHIBIT K



Central Financial Control

P.O. Box 660873
Dallas, TX 75266-0873

(888)233-7880 Phone
(714)937-3427 Fax

August 4, 2015

Retcnick Fausten
P.O. Box 129
Haynesville, VA 22472

CFC Numbers: 964896193 and 971676309
Facility: St. Mary's Medical Center

Dear Mr. Fausten:

Our office has received multiple dispute letters from you concerning the obligations listed above. Previously you were provided with a written response to your disputes on May 15, 2015 and June 19, 2015. Subsequent to the debt validation, you now believe these accounts may be fraudulent and/or do not belong to you.

In order to complete our investigation and resolve this matter, we need your assistance. Please mail a copy of your personal identification (i.e. Driver's License/Identification Card and Social Security Card), so we can verify your identity. If someone other than yourself, without your authorization, received services from our client related to the above noted accounts, please provide a complete police report testifying that identity theft occurred as well as a notarized Fraud Affidavit (enclosed).

Please note we are unable to accept the above required documents via facsimile as they are not legible when faxed. Please mail the documents to: *Inquiry Resolution Service, PO Box 660873, Dallas, TX 75266.*

Unfortunately, without the information requested above, our office is unable to resolve this matter. Upon receipt of the above referenced information, our office will complete our investigation and notify you of the resolution.

Please forward the requested documents within 15 days of this letter so that this office may bring resolution to this matter on your behalf.

Sincerely,

Annette Leyva
Inquiry Resolution Specialist

Enclosure: Fraud Affidavit

EXHIBIT L



Central Financial Control

P.O. Box 660873
Dallas, TX 75266-0873

(888)233-7880 Phone
(714)937-3427 Fax

September 16, 2015

Retenick Fausten
P.O. Box 129
Haynesville, VA 22472

CFC Numbers: 964896193 and 971676309
Facility: St. Mary's Medical Center

Dear Mr. Fausten:

We are in receipt of your letter dated August 8, 2015. Previously you were provided with a written response to your disputes on May 15, 2015 and June 19, 2015. Due to the nature of your new dispute, we requested your assistance on August 4, 2015.

Unfortunately, without the information previously requested, our office is unable to investigate this matter for resolution.

Please mail a copy of **your** personal identification (i.e. Driver's License/Identification Card and Social Security Card), so we can verify **your** identity. If someone other than yourself, without your authorization, provided personal information and received services from our client related to the above noted accounts, please provide a complete police report testifying that identity theft occurred as well as a notarized Fraud Affidavit (enclosed).

If you have any other disputes, or now have additional information relating to the prior dispute, please communicate that new dispute or additional information to this office.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Annette Leyva', written in black ink.

Annette Leyva
Inquiry Resolution Specialist

Enclosure: Fraud Affidavit



Central Financial Control

P.O. Box 660873
Dallas, TX 75266-0873

(888)233-7880 Phone
(714)937-3427 Fax

October 6, 2015

Retnick Fausten
P.O. Box 129
Haynesville, VA 22472

CFC Numbers: 964896193 and 971676309
Facility: St. Mary's Medical Center

Dear Mr. Fausten:

We are in receipt of your Fraud Affidavit and previously requested copy of your Social Security Card. Please be advised the Fraud Affidavit is incomplete and the requested copy of your Driver's License/Identification Card was not received.

Unfortunately, without the information previously requested, our office is unable to investigate this matter for resolution.

Please mail a copy of **your** personal identification (i.e. Driver's License/Identification Card), so we can verify **your** identity. If someone other than yourself, without your authorization, provided personal information and received services from our client related to the above noted accounts, please provide a complete police report testifying that identity theft occurred as well as a **complete**, notarized Fraud Affidavit (enclosed).

Please forward the requested documents within 15 days of this letter so that this office may bring resolution to this matter on your behalf.

Sincerely,

Annette Leyva
Inquiry Resolution Specialist

Enclosure: Fraud Affidavit

EXHIBIT N



Central Financial Control

P.O. Box 660873
Dallas, TX 75266-0873

(888)233-7880 Phone
(714)937-3427 Fax

November 3, 2015

Retcnick Fausten
P.O. Box 129
Haynesville, VA 22472

Patient Name:	Retcnick Faustin
CFC Numbers:	964896193 and 971676309
Facility:	St. Mary's Medical Center
Facility Address:	901 45th St., West Palm Beach, FL 33407
Dates of Services:	August 8, 2009 and August 28, 2009

Dear Mr. Fausten:

We are in receipt of your Fraud Affidavit and previously requested Identification Card. Previously you were provided with a written response to the requested debt validation on May 15, 2015. For your convenience, our office has included a copy of the original response for your review. Due to your concerns outlined in your letters, our office has again thoroughly reviewed your accounts. Based on our review, we have determined that the accounts in question *do* belong to you and are neither fraudulent nor due to identity theft.

The aforementioned accounts result from services rendered by our client, St. Mary's Medical Center. Our office has verified that your account records do exist and are indeed valid and correct. If you would like copies of your records, please contact St. Mary's Medical Center in person.

Our records indicate you were properly notified of the outstanding balances prior to reporting; therefore, deletions are not warranted. Our office does not accept payment for deletion of items on a credit report. Upon receipt of payment in full, we will advise the credit reporting agencies to update your credit profile accordingly.

Based on your identification, description details and information provided to our client at each time services were rendered, the accounts in question belong to you.

If you have any questions regarding your dispute, please feel free to contact us at (888) 233-7880. If you have questions regarding your account, please contact us at (800) 300-7192.

Sincerely,

Annette Leyva
Inquiry Resolution Specialist

Enclosures: Original Response

5. Medicare Patient's Assignment of Benefits and Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges of the hospital and physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by Medicare or other insurance.

6. Legal Relationship Between Hospital and Physician

All physicians and surgeons furnishing services to the patient, including the Emergency Department physicians, radiologists, pathologists, anesthesiologists and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the general and special instructions of the physician.

7. Authorization to Appeal

I hereby authorize the hospital to appeal on my behalf my claim(s) with _____, if applicable, and/or any payor which denies and/or delays payment of my claim(s). I further authorize that the payors, listed herein and any other payors, release any and all information requested and/or related to my claim(s) to the hospital and/or its attorneys. Unless prohibited by applicable law or regulation, this authorization is irrevocable upon execution by me hereinbelow and any appeal brought by the hospital shall be as if it was brought by me personally.

8. Personal Valuables

It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The maximum liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited to five hundred dollars (\$500.00) unless a written report for a greater amount has been obtained from the hospital by the patient.

9. I have Received the Additional Facility Specific Addendum:

Patient Rights and Responsibilities;
Important Message from Champlus;
Important Message from Medicare;
Authorization to Disclose
Other Specific Items as listed here:

☒ Inpatient / Outpatient Information Guide

☐ Booklet regarding Advance Directives/Living Will

Patient has executed Advance Directives: ☐ Yes ☒ No Did you bring a copy? ☐ Yes ☒ No

10. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 1) and Assignment of Benefits to Hospital and Hospital-Based Physicians (Paragraph 2) set forth above.

Date 8/28/09 Financially Responsible Party [Signature] Witness [Signature]

The undersigned certifies that he/she has read and verbalized/demonstrated understanding of the foregoing, received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Date 8/28/09 Patient/Parent/Guardian/Conservator/Responsible Party - The above conditions of services have been explained to me and I understand. [Signature]

If other than patient, indicate relationship _____

Witness _____

Witness _____

A Copy of this Document will be Furnished Upon Request

TCE1240E2 R3/09

CONDITIONS OF SERVICES

Page 2 of 2



DOB: 02/14/1983

26Y M

PT: EQE

ACCT# 054406749 MR# 000293743

FAUSTIN, RETCNICK

AT: SORRENTINO, A AD: SORRENTINO, A

5. Medicare Patient's Assignment of Benefits and Release of Information

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for unpaid charges of the hospital and physician(s) for whom the hospital is authorized to bill in connection with its services. I understand I am responsible for any remaining balance not covered by Medicare or other insurance.

6. Legal Relationship Between Hospital and Physician

All physicians and surgeons furnishing services to the patient, including the Emergency Department physicians, radiologists, pathologists, anesthesiologists and the like, are independent contractors with the patient and are not employees or agents of the hospital. The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its nursing staff to carry out the instructions of such physician. It is the responsibility of the patient's physician or surgeon to obtain the patient's informed consent, when required, to medical or surgical treatment, special diagnostic or therapeutic procedures, or hospital services rendered for the patient under the general and special instructions of the physician.

7. Authorization to Appeal

I hereby authorize the hospital to appeal on my behalf my claim(s) with _____, if applicable, and/or any payor which denies and/or delays payment of my claim(s). I further authorize that the payors, listed herein and any other payors, release any and all information requested and/or related to my claim(s) to the hospital and/or its attorneys. Unless prohibited by applicable law or regulation, this authorization is irrevocable upon execution by me hereinbelow and any appeal brought by the hospital shall be as if it was brought by me personally.

8. Personal Valuables

It is understood and agreed that the hospital maintains a safe for the safekeeping of money and valuables, and the hospital shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics or other articles of unusual value and small size, unless placed in the safe, and shall not be liable for loss or damage to any other personal property, unless deposited with the hospital for safekeeping. The maximum liability of the hospital for loss of any personal property which is deposited with the hospital for safekeeping is limited to five hundred dollars (\$500.00) unless a written report for a greater amount has been obtained from the hospital by the patient.

9. I have Received the Additional Facility Specific Addendum:

Patient Rights and Responsibilities;
Important Message from Champus;
Important Message from Medicare;
Authorization to Disclose
Other Specific Items as listed here:

 / Inpatient / Outpatient Information Guide

 / Booklet regarding Advance Directives/Living Will

Patient has executed Advance Directives: / Yes / No Did you bring a copy? / Yes / No

10. Financial Responsibility Agreement by Person Other than the Patient or the Patient's Legal Representative

I agree to accept financial responsibility for services rendered to the patient and to accept the terms of the Financial Agreement (Paragraph 1) and Assignment of Benefits to Hospital and Hospital-Based Physicians (Paragraph 2) set forth above.

8-8-09

Date

Financially Responsible Party

Witness

The undersigned certifies that he/she has read and verbalized/demonstrated understanding of the foregoing, received a copy thereof, and is the patient, the patient's legal representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

8-8-09

Date

Patient/Parent/Guardian/Conservator/Responsible Party - The above conditions of services have been explained to me and I understand.

If other than patient, indicate relationship

Witness

Witness

A Copy of this Document will be Furnished Upon Request

TCE1240E2 R3/09

CONDITIONS OF SERVICES

Page 2 of 2



DOB: 02/14/1983

26Y M

PT: EQE

ACCT# 054322920 MR# 000293743

FAUSTIN, RETCNICK

AT: SORRENTINO, A AD: SORRENTINO, A

4-17-15

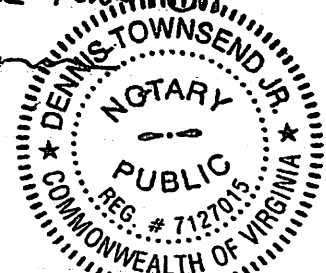
Collection Agency / Attorney
Original creditor: Medical - St. Marys Medical Center FL
(Medical / Health care)
Original Amount \$550 2nd Original Amount \$750

Dear, Collection Agency - Attorney

Am advising you about collection with you reporting credit agency about creditor Medical - St. Marys Medical Center FL amount \$550 and \$750 am disputing this matter asking that you prove agree or signature document that you have receive service from St. Marys Medical center if can't would ask you send all credit agency remove that collection off my credit report will give 30 days to prove if you don't respond before 30 day or prove this collection will take this matter before court of law thank you for your prompt assistance in this matter. I hope you have great day

Sincerely yours Retnick Fausten
R. Fausten

In the county of Richmond
Virginia



This was sworn to on this 17th day of April 2015.

Notary

12/31/18
Expiration

2-4-2015

Retenick Fausten ~~1200885~~ 1200885
~~Haynesville Correctional Center~~
 P.O. Box 129 Haynesville Virginia 22472

Would like to dispute account number 964896193
 wich state owe \$550 date opened Nov 2009 on medical bill
 never was seen by medical Center wich is St Marys
 medical Center FL don't onder stand how you got my information
 this account on my credit report as collection that
 make my credit look bad would like to know how you
 could prove that this account is on me. All so
 account 971676309 for \$750 on 2009 for that
 same place St. Mary's medical Center would like
 to know what procedures verifying document address
 variation nature of this account for collection.
 of you can't prove them am going to ask you to
 remove this information off my credit report
 wich recive from Experian.

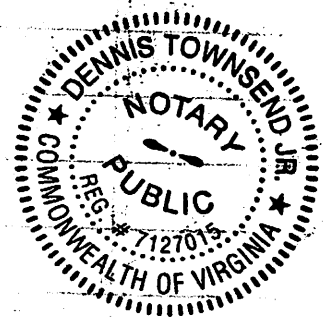
Retenick Fausten - 1200885
R. Fausten

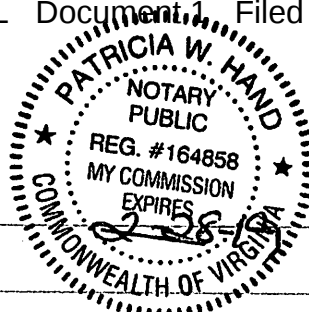
In the county of Richmond, Virginia

This was sworn to me on this 2nd day of December 2014.

D. [Signature]
 Notary

12-31-18
 Expires





County/City of Richmond; Commonwealth of Virginia
The foregoing instrument was subscribed and sworn before me this

25 day of June, 2015
Reticnick Fausten
(Name of person seeking acknowledgement)

Patricia W. Hand
Notary Public

My Commission Expires: 2-28-19
Notary Reg. No. 164858

EXHIBIT Q

June, 2015

Reticnick Fausten - 1200885 (6A-4T)

Dear Central Financial Control and St. Mary's Medical Center

Am Sending dispute letter been advised by your letter dated May 15, 2015 (account # CFC) 964846193 (account # CFC 971676309) date of service August 8, 2009, August 28, 2009 that was patient at St. Mary's Medical center agree terms of the financial agreement did agree on one dated 8-28-09 did not agree on 8-8-09 so ask that can you please that both signature is of me sent letter saying that not my signature on 8-8-09 never showed up ask how both signature do not match sent letter two-week ago this is my final letter this letter is notice resolve with^{out} going court. Or could take this court and have federal court look at your business practice and St. Mary's Medical way charge so call patient. Got same copy you sent me there is fraud going on. So let take step make agreement or I'll take this court. You have 3-week. R. Fausten
Reticnick Fausten.

Patient Name: Peterick Faustin D.O.B 2-14-83 SSI 591-18-9266
Facility: St Mary's Medical Center
Dates of services: August 8, 2009 and August 28, 2009

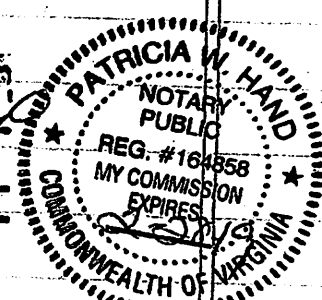
Am told Central financial Control debit collector which have
my information attempt to collect debt on behalf St. Marys Medical
Center. Am challenging contract date Service August 8, 2009, August
28, 2009 am told central financial control that provide driver license
St. Marys Medical Center that copy was made held on file. Am
requesting copy of medical records, driver license any thing that
could prove I physical made vist recive service for medical
reatment. Am questioning my signature that don't match contract
late service August 8, 2009, August 28, 2009 debt collector
claim that on file copy of my driver license could prove that
made vist August 8, 2009, August 28, 2009 send Medical records
haynesville correctional center, P.O. Box 129 Haynesville VA 22472
Thank you.

Peterick Fausten - 1200885
haynesville correctional center
P.O. Box 129
haynesville VA 22472
ly date of birth 2-14-83
SSI 591-18-9266

County/City of Richmond, Commonwealth of Virginia
The foregoing instrument was subscribed and sworn before me this
6th day of August, 2015
Peterick Fausten
(Name of person seeking acknowledgement)

My Commission expires: 7-28-19
Notary Reg. No. 762858

Notary Public



I certify that the above notary is not a party to this action

EXHIBIT T

Date: 7/30/2015

To: Retenick Fausten 1200885
Haynesville Correction Center
Haynesville, VA 22472

From: Health Information Management Department
St Marys Medical Center
901 45th St

West Palm Beach, FL 33407-2413

Re: Name, Date, SSN
Medical Records Request for Retenick Fausten

Ref #:

Dear Retenick Fausten 1200885:

In order to protect the confidentiality of patients, federal law prohibits the release of protected health information without proper authorization.

In order for a request for medical records to be processed properly, the patient name, date of birth, or social security number must appear in the request in order for the patient to be identified. One or more of these details were not found in your initial request.

Please update your request and resubmit it to the facility in order to have your request processed.

Thank you,

Health Information Management Department

HealthPort

P.O. Box 409900
Atlanta, GA 30384-9900
Fed Tax ID 58 - 2659941
1-877-595-9900

EXHIBIT T

Date
7/30/2015
Request ID #
0173962092

Ship to:

Retenick Fausten 1200885
Retenick Fausten 1200885
HAYNESVILLE CORRECTION CENTER
PO BOX 129
HAYNESVILLE, VA 22472-0129

Requested By: RETENICK FAUSTEN 1200885
Patient Name: FAUSTEN RETENICK
DOB: 08082009

Records from:

ST MARYS MEDICAL CENTER
901 45TH ST
WEST PALM BEACH, FL 33407-2413

HealthPort is the largest provider of release of information(ROI) services and technology. We ensure the compliant exchange of protected health information for over 10,000 healthcare facilities nationwide. To learn more about our flexible ROI solutions, go to www.healthport.com/facilityassist